DISPENSE AS WRITTEN PRIOR AUTHORIZATION

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 124 (Rev. 12/2005)

Clear Fields

Fax Completed Form to:
866-254-0761 or 334-321-2199
For questions regarding this prior authorization, call
866-773-0695 or 334-321-0268

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons

- **The generic product was not effective**
- **There was an adverse reaction with the generic product**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug	**Requested Dosage** (must be completed)	**Diagnosis for the request**

Qualifications for coverage:

☐ Failed generic equivalent	Start Date	End Date	Dose	Frequency
☐ Adverse reaction to generic equivalent (attach FDA Medwatch form) or contraindicated (provide description):				

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature	Date

Part II: TO BE COMPLETED BY PHARMACY

Pharmacy Name			ND Medicaid Provider Number
Telephone Number	Fax Number	Drug	NDC #

Part III: FOR STATE USE ONLY

Date Received	CSP MD ☐ Yes ☐ No CSP Pharmacy ☐ Yes ☐ No	Daily Units Bypass Units ☐ Yes ☐ No	Req App	CLM Limit
Approved - Effective dates of PA From: / / To: / /			Approved By	
Denied (Reasons)				